APPEAL NO. 93157

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq*. (Vernon Supp. 1993) (1989 Act). At a contested case hearing held in (city), Texas, on January 22, 1993, the hearing officer, (hearing officer), credited with presumptive weight the report of the designated doctor and concluded that appellant (claimant) reached maximum medical improvement (MMI) on July 28, 1992, with an impairment rating of 0%. Claimant has requested our review urging that additional issues and evidence be considered and asserting, in essence, that the reports of two other doctors who examined her should outweigh the designated doctor's report respecting her having reached MMI with a 0% impairment. The response of respondent (carrier) was not timely filed and thus was not considered.

DECISION

Finding the evidence sufficient to support the hearing officer's findings and conclusions, the decision is affirmed.

In its response, the carrier stated it did not receive a copy of claimant's request for review until March 15, 1992, when a copy was apparently obtained from the Texas Workers' Compensation Commission (Commission) after being requested by the carrier's attorney. However, claimant's request for review bears a certificate of service stating that a copy was sent to the carrier on February 26, 1992, by certified mail, return receipt requested (No. P300219699), and claimant provided the Commission with a copy of a certified mail "green card" (No. P300219699) showing receipt by the carrier on March 1, 1993. Accordingly, carrier's deadline for filing its response was March 16, 1993, and its response, filed March 18, 1993, was not timely. *See* Article 8308-6.41(a); Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 143.4 (Rule 143.4).

After the parties agreed that the two disputed issues from the benefit review conference (BRC) were whether claimant had reached MMI and, if so, what her impairment rating was, the hearing officer considered the claimant's request of January 5, 1993 (Hearing Officer Exhibit 3), for the addition of four issues not identified in the statement of disputes as unresolved in the report of the benefit review officer (BRO), to wit: (1) that carrier has prevented claimant from obtaining medical care since August 10, 1992, by not paying her doctors; (2) that carrier owes claimant $270.17 per week in compensation (apparently referring to temporary income benefits (TIBS)) from July 1992; (3) that carrier owes claimant $48.53 for reimbursement for prescription medicine; and (4) that the carrier, the Commission's designated doctor, (Dr. O), and the Commission's BRO "are involved in a coverup" regarding the diagnosis of her illness in that those parties failed to consider the reports she provided them from (Dr. K), a rheumatologist, and (Dr. G), a psychiatrist. Rule 142.7 provides that additional disputes may be included in the statement of disputes by the unanimous consent of the parties (carrier did not consent), or by permission of the hearing officer upon a determination of good cause. The hearing officer declined to add any of the requested issues to the statement of disputes. He advised the parties that claimant's

second requested issue was in reality "a sub-issue" of the MMI issue. Respecting claimant's first and third requested issues, the hearing officer advised claimant she could seek their resolution under the Commission's medical dispute resolution process. *See* Articles 8308-4.68, 8308-8.26 and Rule 133.305.

As for the fourth requested issue, claimant asserted that Dr. G diagnosed chronic pain syndrome and major depression, that Dr. K diagnosed chronic pain, but that the designated doctor, Dr. O, reported that she had been diagnosed with bursitis, which she disputes is her medical problem. Because Dr. O failed to mention the reports of Drs. G and K in his report, claimant feels that he did not consider the reports and stated he did not examine her for "what I have." Noting also that the carrier and the BRO had the reports of Drs. G and K, claimant posits that "they just kind of swept the real issue aside and dealt with something that they wanted to deal with." It was claimant's theory that her real medical problem all along was primarily the pain in her hips, notwithstanding that her uncontested claim was for an occupational disease (repetitive trauma injury); that neither the designated doctor nor (Dr. V), who had treated her before referring her to Dr. G for pain management, had correctly diagnosed and treated her; and that the carrier stopped paying Drs. G and K (who had correctly diagnosed her pain) which resulted in their stopping her treatment. The hearing officer advised claimant that her complaints respecting her fourth requested issue would be more appropriately brought to the Commission's Compliance and Practices Division. Inferring his finding that no good cause was shown by the claimant, we find no abuse of discretion by the hearing officer in declining to add the four issues to the statement of disputes. Rule 140.1 defines a "benefit dispute" as a disputed issue arising under the 1989 Act in a workers' compensation claim "regarding compensability or eligibility for, or the amount of, income or death benefits."

Claimant's contention at the hearing was that she had not reached MMI, apparently because of her continued pain, and that she had more than 30% impairment. She testified she was hired in November 1987 by (employer) to do secretarial work but soon after commencing employment found she was being assigned to far less sedentary tasks which involved prolonged walking, standing, and carrying, and she began to experience hip pain about one year later. When she complained to her supervisor, she felt threatened with job termination. Apparently she eventually filed a workers' compensation claim for an occupational disease involving repetitious trauma injury to her hips which was not disputed. She said she was initially treated by her family doctor, (Dr. T). His report of May 8, 1989 took her off work for a period of time, stated she had "chronic bursitis (& ? early degenerative arthritis) of hips," and said prolonged standing and walking should be restricted. Dr. T's Initial Medical Report reflecting a visit of April 15, 1991, stated the diagnosis as "Bursitis Hips-Bilateral-Chronic." Claimant testified that Dr. T later referred her to (Dr. MY) who treated her from August to December 1991. However, she said that neither of those doctors treated her for "chronic pain." In fact, Dr. MY treated claimant for the wrong thing, caused her more pain, said he could do nothing more for her, and so she returned to Dr. T

who likewise said he could do nothing further for her. In his report of February 13, 1992, Dr. T, noting her complaints of severe pain in both hips off and on for the past year, stated: "I have done numerous x-rays, tried various modalities and therapies including physical therapy (PT), muscle relaxants, anti-inflammatory drugs, all without avail. She has seen two different orthopedic surgeons who have been unable to arrive at either a definitive diagnosis or any treatment that was of benefit in relieving her symptoms." He said that on physical examination he could find no abnormalities, that her complaints are entirely subjective (which he said does not mean they are not real), and that he had nothing further to offer her.

Records of Dr. MY indicated he first saw claimant on August 20, 1991 and diagnosed hip trochanteric bursitis. He reported that claimant had already been seen by Dr. T and by Dr. V, who had also diagnosed bursitis, and that those doctors tried to relieve her symptoms with various medications and PT. By December 12, 1991, according to Dr. MY, with various medications, injections, and PT not resolving her problem, he was "at a loss for explanation, as well as at a loss for any additional ideas concerning treatment," and suggested she seek another opinion. In Dr. MY's records was an unsigned Report of Medical Evaluation (TWCC-69) stating that claimant had reached MMI on "12-12-91" with a 5% impairment rating, apparently for "pain in greater trochanteric area with slight limitation hip range of motion."

The report of Dr. MC, dated December 19, 1991, to whom claimant was referred for an independent medical evaluation, stated his appraisal to include bilateral hip pain, possibly associated with a greater trochanteric bursitis, together with chronic knee and ankle pain. Noting the "complete lack of significant physical findings," the absence of an "objective basis for [her] inability to return to her pre-injury work," Dr. MC indicated he did not believe claimant would respond either to continued conservative care or to surgery, and stated: "I cannot help but believe that there is (sic) significant non-physiological factors at play here including a relative lack of motivation on the part of the patient and a lack of desire to return to work." He concluded that claimant "has achieved [MMI]," and that her prognosis was "generally good." In a letter of January 25, 1992, Dr. MY said he had read the report of Dr. MC, was in total agreement with Dr. MC's physical exam findings and assessment of claimant, would have no objection to claimant's returning to her previous occupation, and released her to return to "sit down" type work only.

Claimant said she contacted the carrier about her continued pain, was advised she could select another doctor, and selected Dr. V in February 1992. In Dr. V's records of claimant's February 11, 1992 visit, which indicated he was seeing her for a second opinion, Dr. V diagnosed bilateral trochanteric bursitis, left more than right. He noted that the multiple studies, including x-rays and MRIs, were followed by treatments, including Cortisone shots, PT, and laser treatments, all of which were unsuccessful. He felt claimant could return to work with restrictions. He did a bone scan which was normal and tried

several different medications. In March 1992, Dr. V felt referral to a pain control specialist was indicated and referred claimant to Dr. G. Dr. V continued to see claimant periodically to at least June 9, 1992, and in his note of July 28, 1992, stated claimant had reached MMI with no permanent impairment and was released from his care. According to Dr. V's signed TWCC-69, claimant reached MMI on "7/28/92" with an impairment rating of "0%."

Claimant, who testified she had no medical training, stated that at the request of another of employer's insurance carriers, Company, which was paying the balance of her salary (30%) after her TIBS payments (70%), she was examined by (Dr. C) whom she characterized as the first doctor to really care about her pain and correctly diagnose it. A February 28, 1992 report from Dr. C stated that claimant had indicated her "extreme unhappiness" with employer for having hired her for secretarial duties but requiring her to perform far more strenuous tasks. Dr. C said he reviewed the reports of Drs. V, MC, and MY. After his examination, Dr. C felt claimant had "no disability with regard to her hips," but said he would defer a diagnosis pending rheumatological, neurological, and psychological studies.

On August 26, 1992, the Commission selected Dr. O as the designated doctor to examine claimant for MMI and impairment rating. Dr. O's signed TWCC-69, to which was attached his narrative report of October 15, 1992, stated that claimant reached MMI on "7-28-92" with an impairment rating of "0%." He commented that pursuant to the Guides to the Evaluation of Permanent Impairment, third edition, published by the American Medical Association (AMA Guides), the only way claimant's diagnosed condition of bilateral trochanteric bursitis could be rated is on loss of ROM or loss of strength in the hips, and that the various testing he did revealed no such losses. Thus, Dr. O assigned claimant a 0% impairment rating and felt she had reached MMI on July 28, 1992, the date she saw Dr. V, because her condition had not changed since that date.

Dr. G's report of March 24, 1992, stated she had been referred by Dr. V for psychiatric evaluation and pain management. Dr. G noted claimant's great anger and resentment towards her superiors and coworkers concerning her being given menial tasks and not the secretarial position for which she had applied. Dr. G diagnosed "Major Depression, single episode," and "Chronic Pain Syndrome." He prescribed certain medications and referred her for individual psychotherapy. Claimant stated that because the carrier did not want to pay her psychiatric bills and stopped paying Dr. G in July 1992, Dr. G discontinued treatment.

She said that Dr. G felt she needed to see a rheumatologist so in August 1992 she saw Dr. K who said she had "chronic pain." Dr. K's report of August 10, 1992, however, assessed claimant as having a "symptom complex consistent with chronic trochanteric bursitis of the hips." He noted her prior evaluations by a neurologist and two orthopedic surgeons, as well as her negative x-rays, bone scan, and MRI and CT scans. He also

noted her nonresponsiveness to conservative therapy and tried her on Prednisone without success.

Neither of the reports of Drs. G and K mentioned the issues of MMI and impairment rating. However, it was these reports, claimant maintained, that "started the coverup" and which were "swept under the rug." Claimant said that the designated doctor examined her for bursitis, which she said she does not have, and not for chronic pain, which Drs. G and K say she does have. Her theory was that neither Dr. G nor Dr. K have said she has reached MMI, that she wants to be examined and treated by them for her pain, that they may at some time find she has reached MMI, and that in the meantime the carrier has prematurely stopped the payment of TIBS.

Articles 8308-4.25(b) and 8308-4.26(g) provide that the report of the designated doctor shall have presumptive weight and that the Commission shall base its determination of MMI and the impairment rating on such report unless the great weight of the other medical evidence is to the contrary. We are well satisfied here that the evidence sufficiently supports the hearing officer's determination giving presumptive weight to Dr. O's report. Both Dr. O and Dr. V, who had treated claimant for some time, believed she had reached MMI on July 28, 1992 with no permanent impairment, and Drs. T, MY and MC all felt they had nothing to offer her. Dr. MY felt she reached MMI on "12-12-91", albeit with a 5% impairment. Claimant testified she had no medical training and lay testimony will not overcome the presumptive weight accorded the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92312, decided August 19, 1992. Drs. G and K did not opine one way or the other as to whether claimant had reached MMI and had any impairment; however, it is apparent from their records that they were simply trying to assist claimant in obtaining relief from the pain she reported. MMI means "the point after which further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated, based on reasonable medical probability." Article 8308-1.03(32). As we have previously observed: "This will not, in every case, mean that the injured worker is completely free of pain or impairment, or that the injured worker is able to return to the prior occupation. Evidence of impairment must be based on objective clinical or laboratory findings. Article 8308-4.25(a)." Texas Workers' Compensation Commission Appeal No. 92312, *supra*. August 19, 1992.

Claimant attached several documents to her request for review including correspondence to the Commission about the hearing officer's unwillingness to add her requested issues to the statement of disputed issues and her allegation of a "coverup," and correspondence from the John Hancock Mutual Life Insurance Company and her employer related to her salary continuation benefits, and asks us to consider them. We decline to do so. Claimant was twice asked by the hearing officer at the hearing if she desired to offer any additional evidence and she responded she did not. We have previously said we will not consider evidence first offered on appeal if it is cumulative of evidence already offered

or would probably not produce a different result were a remand and new hearing granted. *See* Texas Workers' Compensation Commission Appeal No. 92444, decided October 5, 1992, and Texas Workers' Compensation Commission Appeal No. 92459, decided October 12, 1992.

We do not substitute our judgment for that of the hearing officer where, as here, the challenged findings are supported by sufficient evidence. Texas Employers Insurance Association v. Alcantara, 764 S.W.2d 865 (Tex. App.-Texarkana 1989, no writ). The challenged findings and conclusions of the hearing officer are not so against the great weight and preponderance of the evidence as to be manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 751 S.W.2d 629 (Tex. 1986).

The decision of the hearing officer is affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Thomas A. Knapp
Appeals Judge